

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/28/2011	
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 E COOLSPRING AVE MICH CITY, IN46360			
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: September 27 & 28, 2011</p> <p>Facility number: 010610 Provider number: 010610 AIM number: NA</p> <p>Survey team: Lara Richards, R.N., T.C. Kathleen "Kitty" Vargas, R.N.</p> <p>Census bed type: Residential: 54 Total: 54</p> <p>Census payor type: Other: 54 Total: 54</p> <p>Sample: 9</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 29, 2011 by Bev Faulkner, RN</p>			R0000	<p>The following is the Plan of Correction for Sterling House and Clare Bridge of Michigan City in regards to the Statement of Deficiencies for the annual survey completed on 9/28/2011. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R0123	<p>(h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:</p> <p>(1) The name and address of the employee.</p> <p>(2) Social Security number.</p> <p>(3) Date of beginning employment.</p> <p>(4) Past employment, experience, and education, if applicable.</p> <p>(5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable.</p> <p>(6) Position in the facility and job description.</p> <p>(7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills.</p> <p>(8) Signed acknowledgement of orientation to residents' rights.</p> <p>(9) Performance evaluations in accordance with facility policy.</p> <p>(10) Date and reason for separation.</p> <p>Based on record review and interview, the facility failed to ensure documentation of a job specific orientation was maintained in the employee personnel records for 2 of 5 records reviewed. (Maintenance Employee #1 and Dietary Employee #3)</p> <p>Findings include:</p> <p>1. The personnel record for Maintenance Employee #1 was reviewed on 9/28/11 at 11:30 a.m. The employee was hired on 5/13/11. There was no documentation in the employee's personnel file that a job specific orientation was completed.</p>			R0123	<p><u>R 123 Personnel-Non-conformance</u> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <ul style="list-style-type: none"> No residents were identified as affected by the alleged non-conformance. Employee #1 (Maintenance) now has documentation of a job specific orientation in file, in addition to previous information, which included: name, address, Social security number, date of beginning employment, record of past employment, experience and education, signed job description, documentation of community orientation, including resident rights and other state required documentation of training, signed acknowledgment of resident rights. Employee #3 (Dietary) now has documentation of a job specific 		10/27/2011

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	<p>2. The personnel record for Dietary Employee #3 was reviewed on 9/28/11 at 11:30 a.m. The employee was hired on 6/11/11. There was no documentation in the employee's personnel record that a job specific orientation was completed.</p> <p>Interview with the Health and Wellness Director of the Clare Bridge Cottage building on 9/28/11 at 2:40 p.m., indicated there was no documentation of a job specific orientation for the two employees in their personnel records.</p>				<p>orientation in file, in addition to previous information, which included: name, address, Social security number, date of beginning employment, record of past employment, experience and education, signed job description, documentation of community orientation, including resident rights and other state required documentation of training, signed acknowledgment of resident rights.</p> <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> Associate files will be audited using the existing Brookdale state of Indiana checklist, to which has been added: Job specific orientation for all associates. In the event any records are found to be incomplete, the Administrative Assistant, Executive Director/ Department Manager/designee will be responsible for completion of the job specific orientation documentation.. <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> The Administrative Assistant, as well as department managers affected (Dietary and Maintenance) will be re-educated on documentation expectations for their associates. The Executive Director/Designee will review all new associate files and a portion of all associate records monthly to monitor for compliance. <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p>		

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R0144	<p>(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure a clean environment was maintained and that it was in a state of good repair related to marred walls and doors, stained carpet, marred kick plates on doors, dust on lights, and burnt out light bulbs in 2 of 2 buildings. This had the potential to affect the 26 residents who resided in the Sterling House and the 28 residents who resided in the Clare Bridge Cottage.</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 9/28/11 at 12:35 p.m., with the Maintenance Supervisor, the following was observed in the Clare Bridge Cottage:</p> <p>a. The top of the closet door in Room A-5 was scratched and marred. One resident resided in this room.</p>		R0144	<p>The Administrative Assistant will complete an audit of each associate file and report results to the Executive Director, who will be responsible for ensuring each department manager completes documentation of the job specific orientation .</p> <p>By what date will these systemic changes be implemented?</p> <p>October 27, 2011</p> <p><u>R 144 Sanitation and Safety Standards</u></p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p><i>In the Clare Bridge:</i></p> <ul style="list-style-type: none"> The top of the closet door in Apartment A5: has been repaired and cleaned. The door frame to Apartment A1: Door frame repaired and cleaned. The bathroom walls in Apartment B6: Walls have been repaired and cleaned. The bathroom light bulb in apartment B 9: Bulb has been replaced. The "B" hallway carpet: Facility has contracted with vendor for professional carpet cleaning. B hall has been cleaned. The walls of B hall shower rooms, and door of the B Hall shower room: Walls and door have been painted and cleaned. Two chairs in B hall lounge: Have been repaired. The toilet paper holder in C 1: Replaced . 		10/27/2011	

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	<p>b. The door frame to Room A-1 was paint chipped. The bathroom walls were also scratched and marred. One resident resided in this room.</p> <p>c. The bathroom walls in Room B-6 were scratched and marred. One resident resided in this room.</p> <p>d. The bathroom light bulb was burnt out in Room B-9. The kick plate on the base of the door was also discolored and scratched. One resident resided in this room.</p> <p>e. Multiple areas of discoloration were observed on the carpet in the "B" hallway.</p> <p>f. The walls in the B hall shower room were scratched and marred. The door to the shower room was also scratched and marred at the base.</p> <p>g. Two of two chairs in the B hall lounge had scratched and marred chair legs.</p> <p>h. There was no toilet paper holder in the bathroom of Room C-1. The bathroom walls were also scratched and marred and the door to the resident's room was also scratched and marred. One resident resided in this room.</p> <p>i. The kick plate on the door of Room</p>			<ul style="list-style-type: none"> · The kick-plate on the door of C-6: repaired and cleaned. · Urine odor in D-6: Bathroom re-cleaned. · Dust accumulation in the D Hall bathroom light fixture: Fixture has been cleaned. · Base of walls located across from the dining room: Walls have been repaired, painted and cleaned. · Base of walls in dining room: Walls have been repaired, painted and cleaned. · Door leading to the Kitchen area: Door has been repaired and cleaned. · Discolored carpeted area between living room and dining room: Carpet has been cleaned. · Cracked tiles in kitchen have been filled and or repaired. <p><i>In the Sterling House:</i></p> <ul style="list-style-type: none"> · The burnt out light bulbs in Front Meeting room: Light bulb replaced. · Cracked tiles in kitchen. Cracks have been filled and repaired. <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Maintenance Director will complete monthly preventative maintenance log. Executive Director and or Designee will review and monitor for compliance. Additional training for Housekeeping staff will be completed. Maintenance Director and or designee will monitor for compliance. <p>What measures will be put in place or what systemic changes will the</p>			

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	<p>C-6 was scratched and discolored. One resident resided in this room.</p> <p>j. A urine odor was noted in Room D-6. One resident resided in this room.</p> <p>k. There was an accumulation of dust and debris in the light fixture cover in the D hall bathroom.</p> <p>l. The base of the walls located across from the Dining Room were paint chipped and marred.</p> <p>m. The base of the walls in the Dining Room were paint chipped and marred.</p> <p>n. The door leading to the Kitchen Area in the Dining Room was paint chipped and marred. The kick plate at the base of the door was discolored and scratched.</p> <p>o. There were areas of discoloration in the carpet leading from the living room to the dining room.</p> <p>Interview with the Maintenance Supervisor at the time, indicated the building was in need of painting and repair.</p> <p>2. During the Environmental Tour on 9/28/11 at 1:15 p.m., with the Maintenance Supervisor, the following</p>		<p>facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> Maintenance log will be placed in a common area for staff, residents and families to report any routine maintenance concerns. Maintenance Director and Executive Director will monitor for response and completion of requests. <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p> <ul style="list-style-type: none"> Executive Director and Regional Directors will continue to monitor systems and training to ensure compliance. <p>By what date will these systemic changes be implemented?</p> <ul style="list-style-type: none"> October 27, 2011 		

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	<p>was observed in the Sterling House:</p> <p>a. There were burnt out light bulbs in the light fixture located in the Front Meeting Room.</p> <p>b. Cob webs were observed around the light fixture in the kitchen area in Room 140. An accumulation of dust was observed on all 4 light bulbs located above the bathroom sink and areas of discoloration were observed on the carpet in the living room area. One resident resided in this room.</p> <p>c. The kick plate at the base of the door to Room 132 was scratched and discolored. One resident resided in this room.</p> <p>d. An accumulation of dust was observed on 4 of 4 light bulbs located above the bathroom sink in Room 127. One resident resided in this room.</p> <p>e. The bathroom door frame in Room 120 was paint chipped and scratched. One resident resided in this room.</p> <p>f. A urine odor was noted in Room 110. A light bulb was burnt out above the bathroom sink. One resident resided in this room.</p>						

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R0154	<p>g. The kick plate located at the base of the door to Room 103 was scratched and discolored. One resident resided in this room.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all of the above areas were in need of cleaning or repair.</p> <p>(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure the kitchen areas and equipment were clean and in good repair, related to lime build up on dishwashers, soiled freezer floor, microwave oven and stoves and broken floor tile for 2 of 2 kitchens. (Sterling House Kitchen and Clare Bridge Cottage Kitchen)</p> <p>Findings include:</p> <p>1. The following was observed on 9/27/11 at 9:25 a.m., during the initial Kitchen Sanitation Tour of the kitchen in the Sterling House building :</p> <p>a. There was lime buildup on the top of the dishwasher.</p>		R0154	<p><u>R 154 Sanitation and Safety Standards-Dietary</u> <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</i></p> <p>No residents were identified as affected by the alleged non-conformance.</p> <p>Sterling House</p> <p>A Lime buildup on the top of dishwasher. Dishwasher has been cleaned.</p> <p>B Grease buildup on metal back splash of stove. Back splash has been cleaned.</p> <p>C. Burnt food debris on stove top. Stove has been cleaned.</p> <p>Clare Bridge</p> <p>a. Bottom of freezer had food debris and was in need of cleaning. Freezer has been cleaned.</p>		10/27/2011	

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	<p>b. There was grease buildup on the metal back splash of the stove.</p> <p>c. There was burnt on food debris on the top of the stove.</p> <p>Interview with Dietary Employee #1 at the time of the tour, indicated the above areas were in need of cleaning.</p> <p>2. On 9/27/11 at 9:45 a.m., the following was observed during the initial Kitchen Sanitation Tour of the Clare Bridge Cottage building :</p> <p>a. The bottom of the freezer had an accumulation of food debris and was in need of cleaning.</p> <p>b. The door to the microwave oven was soiled with a buildup of grease and dirt, the inside of the microwave oven had food debris splatter and was in need of cleaning.</p> <p>c. The front of the dishwasher had lime buildup.</p> <p>d. Twenty-five (25) dessert dishes were stacked wet on the shelf.</p> <p>Interview with Dietary Employee #2 at the time of the tour, indicated there was no</p>		<p>b. Microwave was in need of cleaning. Microwave has been cleaned.</p> <p>c. Front of dishwasher had lime buildup. Dishwasher has been cleaned.</p> <p>d. Dessert dishes stacked on shelf while wet after being washed. Dessert dishes removed, rewashed and fully dry before stacking.</p> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p> <p>· No residents were identified as affected by the alleged non-conformance.</p> <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <p>· Dining Manager and or designee will provide additional staff training for proper cleaning of equipment and storage of dishes.</p> <p>· Dining Manager and or designee will review daily and weekly cleaning schedules to ensure compliance.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?</p> <p>· Executive Director and Regional Dining Support members will continue to monitor for compliance. Executive Director will determine , based on audit findings, when corrective action will be required going forward.</p>		

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R0349	<p>space to allow the dessert dishes to dry before stacking them.</p> <p>Interview with Dietary Employee #1 on 9/28/11 at 12:35 p.m., indicated the above areas were in need of cleaning and/or correcting.</p> <p>3. During the Kitchen Sanitation Tour on 9/28/11 at 12:15 p.m., of the Clare Bridge Cottage building, the following was observed:</p> <p>a. The floor tiles along the entire length of the floor in front of the steam tables, were cracked.</p> <p>Interview with the Maintenance Supervisor on 9/28/11 at 2:45 p.m., indicated the floor tiles needed to be replaced.</p> <p>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:</p> <p>(1) Complete.</p> <p>(2) Accurately documented.</p> <p>(3) Readily accessible.</p> <p>(4) Systematically organized.</p> <p>Based on record review and interview, the</p>			R0349	<p><i>By what date will these systemic changes be implemented?</i></p> <p>10-27-11</p> <p><u>R 349 Clinical</u> <u>Records-Non-compliance</u> <i>What</i></p>		10/27/2011

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	<p>facility failed to maintain clinical records that were complete and accurately documented related to the effectiveness of an as needed (prn) pain medication for 1 of 7 records reviewed. (Resident #1)</p> <p>Findings include:</p> <p>The record for Resident #1 was reviewed on 9/27/11 at 10:45 a.m. The resident was readmitted to the facility on 8/15/11 after being hospitalized for a fractured hip. A Physician's Order, dated 8/15/11, indicated the resident was to receive Hydrocodone (a pain medication) 5/325 milligrams (mg), 1 tablet as needed for pain every 4 hours.</p> <p>The August 2011 Medication Administration Record (MAR), indicated the resident received the Hydrocodone on the following dates and times:</p> <p>8/19/11 at 5:40 a.m. and 12:00 p.m. 8/22/11 at 1:40 p.m. 8/23/11 at 8:45 a.m. and 12:45 p.m. 8/24/11 at 8:50 a.m. and 1:15 p.m. 8/26/11 at 1:10 p.m. 8/27/11 at 7:00 a.m. 8/31/11 no time documented</p> <p>There was no documentation on the back of the MAR or in the Nursing Progress Notes to indicate if the medication was</p>				<p>corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident # 1: Resident 1 was not adversely affected as a result of the alleged non-compliant documentation issue. Residents are routinely assessed for pain management needs by the nursing staff providing care. · Nursing staff will be re-educated by the Health and Wellness Director/Designee regarding documentation of as needed medications. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Other residents who receive PRN (as needed) medications have the potential to be affected by the alleged deficient practice, therefore the Health and Wellness Director and / or designee will re-educate nurses on the documentation expectations. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · The Health and Wellness Director/Designee will conduct routine audits of resident medication administration records (MARS) to determine compliance. Results of audits will be presented to the Executive</p>		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 09/28/2011	
NAME OF PROVIDER OR SUPPLIER STERLING HOUSE OF MICHIGAN CITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 E COOLSPRING AVE MICH CITY, IN46360			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>effective.</p> <p>The September 2011 MAR, indicated the resident had received the Hydrocodone on 9/7, 9/12, and 9/24/11. Again, there was no documentation on the back of the MAR or in the Nursing Progress Notes to indicate if the medication was effective.</p> <p>The facility policy titled, "Medications and Treatments-Administration: As needed "prn" (Medications) was provided by the Health and Wellness Director on 9/28/11 at 12:00 p.m. The policy was identified as current. The policy indicated the following: allow time for prn medication to work, determine the results of the prn medication, document on the back of the MAR the results of the medication being given, and if additional follow-up is indicated by resident's condition, contact the nurse for further instructions.</p> <p>Interview with the Health and Wellness Director on 9/28/11 at 2:30 p.m., indicated the results of the medication should have been documented on the back of the MAR or in the nursing progress notes.</p>			<p>Director/Designee weekly and corrective action determined, based on audit findings. · Change of shift MAR review to include PRN documentation is complete will be put in place.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place? · Weekly and monthly MAR audits will be conducted by HWD and or Designee to ensure compliance.</p> <p>By what date will these systemic changes be implemented? · 10-27-11</p>			